

**Grand County EMS  
Administrative Division**

P O Box 1457  
Granby, CO 80446  
(970)887-0158

**Direct Payment Authorization Agreement**

**Patient Name:** \_\_\_\_\_

**Patient Number:** \_\_\_\_\_

**Call Number(s):** \_\_\_\_\_

**EMS Balance:** \_\_\_\_\_

Misc Fee's: \_\_\_\_\_

Total amount due: \$ \_\_\_\_\_

I authorize Grand County EMS to keep my signature on file and to automatically charge the Visa/Mastercard/Discover account shown below for regular payments of my current balance for ambulance services.

I authorize a reoccurring MONTHLY payment charge to my credit/debit card in the amount of \_\_\_\_\_/100s Dollars (\$\_\_\_\_\_), to be processed on the \_\_\_\_\_ of each month for one year. I acknowledge that any additional ambulance services I may require within one year from execution of this instrument may result in an increase in the regular payment amount shown above.

I understand that this form is valid for one year unless I cancel this authorization through written notice to Grand County EMS at least fifteen (15) days in advance of an automatic payment charge.

Cardholder Name: \_\_\_\_\_

Cardholder Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Card Type:  Visa  Mastercard  Discover

Account Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Expiration Date: \_\_\_\_ / \_\_\_\_

Cardholder Signature \_\_\_\_\_ Date \_\_\_\_\_